



**Prescription Drug Coverage Determination Form**  
Growth Hormone Receptor Antagonist  
Somavert® (Pegvisomant)

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-647-2240.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

**Prior Authorization Criteria:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Is the patient 18 years of age or older?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does the patient have a diagnosis of acromegaly?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Has the patient received treatment with Somavert® for the past 6 months?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes:   |                              |                             |
| ▪ Has the patient demonstrated a significant decrease in insulin-like growth factor-1 (IGF-1) level with Somavert® therapy?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has the patient received any of the following therapies for acromegaly: surgery, radiation therapy, or medical treatment?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes;   |                              |                             |
| ▪ Did the patient have an inadequate response to therapy, or has the physician considered treatments other than Somavert® for acromegaly but rejected as inappropriate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Prior to initiation of therapy, did the patient have an insulin-like growth factor-1 (IGF-1) level above the age and gender adjusted normal range?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Will the patient have IGF-1 levels monitored at 6 months intervals after IGF-1 levels stabilize within normal range?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Will the liver function test be monitored as recommended during therapy?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

---

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.